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CLINICAL LECTURE.

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Reported by ERNEST B. SANGREE, A. M.

TUMOR IN PAROTID REGION.

GENTLEMEN: The first case I bring before you is a young woman who has a tumor in the parotid region. Now what are we to do first? Make a diagnosis. Here, then, is our diagnosis or attempt at a diagnosis. Let us begin with the premise that we have a tumor in a certain anatomical region. We know that there are certain regions of the body, such as the back, the arms, or the buttocks, in which if there be a tumor, we have but little concern about its removal; for we know that there is no danger of wounding any of the vital structures; in fact, a mere tyro could perform the operation. But there are other regions again, such as the groin, the abdomen, or the neck, on which, when we operate, we have the greatest possible concern. Here the exactest anatomical knowledge and the highest excellence of the surgeon's skill are required, for we tread on the confines of death.

So far as we are concerned at present, however, there is no other part of the body than the neck, and let us now consider this region more particularly. How can we arrive at a positive diagnosis in any case? Only by exclusion, *i. e.*, knowing what a thing is by knowing what it is not.

In considering a given region with respect to a tumor, we first call to mind the tumor that is most common in that region. For instance, in the groin, we at once think of hernia, and next of an enlarged lymphatic gland; in the back, lipomata or fatty tumors are most common; in the scalp, we ask ourselves, is it a sebaceous cyst?

Of course this does not imply that we have to deal with the tumor most common to that region, but we naturally begin with that which is most familiar and plain, and thence go to that which is more obscure and recondite.

Should the characteristics of the tumor in question not be those of the most common, then we go around the circle of possible tumors till we find one with which the phenomena do accord.

Reasoning in this way, let us ask ourselves "what may this tumor in the parotid region be?" It may be an enlarged lymphatic gland, a lipoma, sarcoma, fibroma, a sebaceous cyst, carcinoma, angioma, or an enlargement of the parotid gland. We have not exhausted the possibilities, but this will do for our purpose.

Putting my hand on the tumor, I can make out no pulsation; therefore it is not an aneurism. It has not the elastic feel of a sebaceous cyst, nor can I almost close my fingers around it as we can generally do with those tumors. Instead of that it has a fixed base and a feeling of resistance like that of a fibroma.

Sometimes it happens that a lymphatic gland connected with the parotid will enlarge so much that the constant pressure will cause the absorption of the parotid gland, the lymphatic taking its place. Perhaps, as I said, it may be the parotid itself. Well, we must be prepared for any emergency. If this be the parotid gland, it shall come out. Some say that this gland cannot be removed without causing the patient's death. In reply to this belief, I have only to say that the parotid has several times been removed by me, and the patients are still living.

But with regard to this tumor: am I able to differentiate it before the knife has been applied? I am free to admit that I cannot say positively what it is; but there is one important point with relation to it about which I am absolutely certain, and that is this: whatever the growth is, remove it. If the tumor be not taken out, we should probably find it enlarging and enlarging till it would interfere with some of the vital structures in the cervical region, and thus finally put an end to the girl's life. So then, although we are in doubt as to the histology of the tumor and the name that belongs to it, we are in no doubt as to the proper course to pursue.

My classification of tumors I consider exceedingly simple and yet perfectly satisfactory for all surgical purposes. I divide them into two great classes: the Explainable and the Non-explainable; that is, the first — generally known as benignant—carry with them their own explanation; and the second —malignant—are as yet without explanation. The indications in a tumor of the first class are to treat it *secundam artem;* in the second, to remove it or to let it be, doing either of these according as the tumor is large or small, circumscribed or disseminated through much of the surrounding tissues.

Before cutting down on the tumor, I rapidly revolve in my mind the important structures in this region—structures that I must avoid: for instance, the external jugular vein and the veins that give rise to it, the external carotid artery, the pneumogastric nerve.

The patient is now etherized, and I take the first step in the operation: uncover the tumor. My assistant now holds the growth well up with a pair of volsella forceps, so that I can slip my knife around the tumor as close as possible to its surface, in order to avoid wounding any large vessels. In spite of this care, the blood spurts forth in such a manner as to show that we have cut a vessel or two of some size. Here is one of the many situations in which it is so important that a surgeon keeps his presence of mind. My assistant simply presses his finger down into the cavity from which the blood wells, till I have entirely removed the tumor; and now we have both time and opportunity to grasp with the hæmostatic forceps these several bleeding points, preparatory to applying ligatures.

The object of this operation is now removed and in my hand; but I am not even yet determined as to its character, though it looks much like a malignant growth, a scirrhoma. It will be given to the histologist for microscopical investigation.

CARCINOMA OF THE BREAST.

The next case is that of a woman of 47, afflicted with fungus hæmatodes. But what is the growth? "It is a cancer," answers one. No; I should rather call it simply a phenomenal expression of cancer.

Let us speak philosophically. Carcinoma is a certain something, an entity, which the senses cannot grasp; just as man is an entity which no one ever saw, but of which all men are expressions. So in carcinoma; all so-called cancers are merely phenomenal expressions of an ideal growth; and fungus hæmatodes, then, is one expression of an ideal vice.

The case is most pitiable. On her breast you see a large cauliflower-like growth as large as two good-sized fists. From this repulsive-looking object comes an odor of an indescribably nauseating sort, so that it actually saps

the vitality of all who smell it, both patient and friends. Characteristics of this kind must make the woman's life a burden not only to herself, but to her friends also, in spite of their earnest protestations to the contrary.

A case like this strongly reminds me of the story of Sindbad the Sailor's experience with the Old Man of the Sea, in the Arabian Nights. You remember that he fastened himself on Sindbad's shoulders, and made the poor castaway carry him about for days, till finally the adventurous sailor, by a clever trick, managed to shake off the unwelcome burden. We are now about to shake off this "old man of the sea," a far worse one than Sindbad had; but will he manage to regain his seat? You who have seen such instances as these know the probability.

Ordinarily, the best incision in a case where the chain of glands running to the axilla is involved, is in the line of that chain; but here, on account of the irregular character of the growth, we cannot choose our line, but shall simply have to do the best we can.

When the vitality is so low as that of this woman, it is desirable that not a drop of blood be lost. We shall approach this desideratum as near as possible by applying the hæmostatic forceps as soon as a bleeding point appears.

The patient is now fully under the ether; so we begin. I carry my incision around the growth, dissect back skin and fascia, and remove everything down to the sheaths of the muscles. But, as I said, some of the chain of glands running to the axilla are affected. These must also be removed, or the operation would be of little value; so I enlarge the wound and remove all that are involved. We will now remove the hæmostatic forceps, one by one, and those vessels that continue to bleed will be tied.

The surface of the wound is now carefully washed with the antiseptic solution which we have successfully used of late: the silico-fluoride of sodium, gr. $\frac{1}{2}$ to the $\mathfrak{Z}$, and the edges of the wound are brought together with catgut sutures. Fortunately, on account of the flaccid condition of the skin, we have enough flap for our purpose, although I had expected that part of the wound could not be covered, and would have to be left to heal by granulation. In the most dependent parts of the incision we have put small drainage-tubes; the whole is covered with gauze saturated with the antiseptic solution; the arms are bandaged so that no tension will be allowed on the stitches; the woman will be sent to the wards, and the rest must be trusted to the healing hand of nature.

THE USE OF ELECTRICITY IN THE DISEASES OF WOMEN, INCLUDING THE PRACTICE OF ELECTROLYSIS.

BY G. BETTON MASSEY, M. D.,

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THIRD PAPER.

THE FARADIC CURRENT IN GYNÆCOLOGY.

THIS easily produced current has been quite extensively used in direct pelvic applications, especially during the embryonic period of electro-therapeutic work, when the average operator considered one form of electricity about as good as another. Of late its employment has been much circumscribed as compared with the galvanic, based on a more general recognition of its limited physical capabilities; but the same scientific considerations have also indicated certain conditions in which it is pre-eminently useful. These physical qualities and peculiarities are best studied in much the same way as advised for galvanic currents, occasion being taken for a comparison of the two at the same time.

Faradic Apparatus.—The choice of a Faradic apparatus for gynæcological use is by no means so important as that of a galvanic apparatus, and it is somewhat unfortunate that a number of writers and manufacturers have been led to perplex the minds of average readers with speculative differences in the currents produced by different coils. In view of the vast divergence between galvanic and Faradic currents, these mystical peculiarities sink into utter insignificance, and their recognition only serves to obscure facts

of real importance. As the result of a long personal study of the subject, it is my deliberate conviction that all usable strengths and qualities of a Faradic current are obtainable from a single secondary coil of sufficient power by using the ordinary means of graduation forming a part of the battery. There is even, in my opinion, no therapeutic difference between the primary and secondary currents of Faradic coils beyond the fact that the latter gives a far higher range of current strengths.

In the selection of a Faradic apparatus, therefore, such questions may be safely left to the judgment of the manufacturer. Of the more mechanical parts, certain features require to be looked into, and this is especially true of the spring interrupter. A clear note from the apparatus is important in gynæcological applications, as this indicates a regular succession of currents of even strength and duration. An irregular, jarring, discordant note emitted by a spring shows an unfitness for therapeutic work, as the irregular currents produced give unnecessary pain and fail to excite the tonic muscular action aimed at. The Du Bois Reymond method of graduating the strength of the current, by sliding the secondary coil over the primary, is especially well adapted to gynæcological applications when Flemming's excellent cog-wheel mechanism for moving the outer coil is added. This apparatus, shown in the cut of cabinet battery in a previous paper,[1] is too bulky for portable batteries, but furnishes the most even method of gradually increasing and decreasing the current without shock —a desideratum in pelvic applications.

Principles Involved in the Production of Faradic Currents.—As a help to understanding the peculiarities of this current, a brief statement may be given of its mode of production.

If a Faradic battery, as received from the manufacturer, be critically examined it will be seen to consist of three parts: A cell; an arrangement of two coils, one placed over the other, with an iron core in the center; and one or more devices for automatic current interruption. The cell in the portable battery is usually of the Grenét pattern with a removable zinc, and electro-poion fluid as the exciting liquid, but in stationary batteries two Law or Leclanché cells give much greater satisfaction, and save the watching and renewals demanded by the acid cell. The current from the cell does not reach the patient in any way, but is merely used to animate the coil in the following manner: From the cell it circulates through the inner coil of coarse wire, passing thence to the interrupter and back to the cell. During its passage through the coil the current makes the iron core magnetic, and thus attracts the bit of iron on the spring, drawing it towards itself and breaking the circuit. The circuit of the cell current being now broken, all magnetism in the iron core ceases and the spring returns by its elasticity to its platinum contact, restoring the cell current and causing the same series of phenomena to be repeated. It is evident that the rapidity of this make and break of the cell current by the vibrating spring depends mainly on the distance traversed by the spring at each vibration; hence, the platinum point, which does the double duty of controlling the spring and conducting the cell current, is attached to a screw, by which this distance may be regulated with great nicety.

About the electro-magnet, formed by the iron core and the inner coil, the long fine wire of the secondary coil is wound. It is not connected in any way with the circuit carrying the cell current, but is merely close to it. In it the currents conveyed to the patients arise by induction at the moments when the cell current is broken by the interrupter. Each current thus produced in the secondary coil is of almost infinitesimal duration (four one-thousandths of a second, according to Blaserna). What is called the Faradic current is consequently a series of remarkably short current productions, following each other rapidly or slowly as a fine spring, a coarse spring, or a pendulum is used to interrupt the cell current. The Faradic current is there-

[1] Phila. MEDICAL TIMES, April 2d, 1888, page 392.

fore essentially a broken current and is never continuous.[2]

Management of the Apparatus and Method of Controlling the Strength of Faradic Currents.—To put the battery in action, insert the zinc, and make the proper connection tight if an acid cell is used; if a Law or Leclanché cell, close the cell circuit by a switch. If the interrupter does not begin action immediately, tap the screw-head over the platinum point lightly. Adjust the screw to as clear a note as possible, if it is not already adjusted. If an experiment or application be contemplated the battery should now be set for its weakest current, and the secondary circuit left open somewhere—a precaution against unwittingly shocking a patient that should be invariably followed. In gynæcological applications, the active electrode is next carried to its proper situation, and the indifferent electrode adjusted in contact with the body surface before the secondary circuit is closed, and the current is then gradually increased from zero to the strength desired.

Flemming's portable Faradic battery is set for its weakest current when the switch rests on the button marked 1, with the tube covering the iron core pushed in as far as it will go. The current is increased most gradually by withdrawing the tube slowly to the extent desired; the increase by moving the switch from 1 to 2, and so on, is much more abrupt, and is best done when the circuit is broken and the tube pushed in.

The Du Bois Reymond apparatus is set for its weakest secondary current when the outer coil is slid as far away from the inner coil as the space admits. A reverse action, *i. e.*, the sliding of the outer coil back over the inner, increases the current in the secondary coil in a very gradual manner. As the position for weakest secondary current corresponds to that for strongest primary inductions (a current, by the way, that I never use) a preliminary glance to see if the switches are right may save the patient an unpleasant surprise.

Indications for the Use of Covered and Bare Electrodes with Faradic Currents.—The use of a moist conductor to convey the Faradic current through the skin to nerves and muscles beneath it is fully as important as in the case of the galvanic current; for, although the former current leaps from a dry metallic disc to the skin with great facility, and is therefore best adapted to the dry-brush method of stimulation, it expends its action at such times almost entirely on the dermic surface and nerve-ends, the polar region being extremely superficial. The moist covering permits a greater penetration and extension of this region; hence, a deeper action with less surface pain. Within moist cavities, however, the use of a moistened covering on the exposed conducting surface of the electrode is totally unnecessary, as the moisture of the cavity itself readily favors this distribution of the current. The bare electrode is, moreover, introduced into such cavities with greater ease. Such electrodes should, of course, be properly insulated, to protect the vulva and other parts not designed to be affected.

Experimental Comparison of the Electromotive Force or "Pressure" of the Faradic Current with that of the Galvanic Current. — This may be roughly done by touching simultaneously, with dry fingers, the bare terminal wires of a full-strength galvanic battery. No current is felt, since the sixty to ninety volts of pressure in such a galvanic current are not sufficient to make the current jump through the minute layer of air between the finger and the wire; moist fingers permit a little to get through. If, now, the dry fingers be simultaneously brought in contact with the bare terminals of a Faradic current of merely medium strength considerable tingling will result—its pressure is amply sufficient to cause it to leap through this air space.

There are two practical applications of this fact besides its demonstration of the main quality of electromotive pressure; one indicates the need of a more careful insulation of the Faradic

[2] A slowly-run dynamo also produces disconnected currents, but when running at full speed the inductions follow each other so rapidly as to become blended together into a truly continuous current.

current to prevent accidental shocks; and the other, the greater adaptibility of this current for the electric brush application to the body surface. It should not be understood that the greater penetrating power of the Faradic current applies to good conductors, such as the moist tissues of the body, for here the galvanic current is most efficient, as the penetration is by conduction, not disruption. It is only in the disruptive penetration of poor conductors, such as dry cuticle and air, that the Faradic current shows greater power. Exact measurement of this volt force of Faradic currents are, unfortunately, wanting, but they probably vary from several hundred to several thousand volts.

Experimental Proof of the Inappreciable Volume of Faradic Currents.—Place a milliampere meter in circuit with the secondary coil by including it directly between the poles of the battery, and turn on the full strength of the current, the meter will not show even the fraction of a milliampere. The minuteness of its volume is also shown in its failure to decompose water, salts, or organic compounds, and in the practical absence of all tissue irritation, congestion or cauterization when it is passed through the body.

Action of the Faradic Current on Sensory Nerves and Muscles.—Notwithstanding the exceeding weakness of this current in "bulk" or "volume," the great requisite for usefulness in the mechanic arts, and in the chemical destruction and metamorphosis of tissue, a slight acquaintance with its action on any part of the body is apt to impart an exaggerated idea of its physiological powers. Being essentially a series of exceedingly abrupt current creations, its power to excite the functions of nerves and muscles is unique, and the manifest phenomena of pain and muscular contraction conceal its total inability to produce profounder impressions on the body. A nerve or muscle, brought within either polar region, is thrown into action as each induction arises, just as an abrupt variation of the galvanic current, whether a rise or fall, produces a similar phenomenon. Each induction produces a separate stimulus therefore, and it is only when they follow each other very rapidly, as when a rapid interrupter is used, that the separate stimulations seem to blend together, producing a continuous contraction or sensation. Even then the impressions on the nerve are those of distinctly separated, though rapidly successive, currents.

The Faradic susceptibility of the sensory nerves of the limbs and trunk is fully shared by those of the pelvis, although the lessened sensibility of the normal uterine and ovarian nerves permits the employment of current strengths not bareable on the skin surface. The vulva, on the contrary, like other muco-epidermic junctions, is exquisitely sensitive to this stimulus, and should be protected from it in all ordinary applications by well-insulated electrode stems. The sensibility of the vagina is about midway between the two.

As to the therapeutic applicability of this current, there is no doubt whatever but that the muscular tissue of the vaginal sphincters, the uterus, the bladder and the urethra can be stimulated into tonic contraction by powerful and well-directed Faradic currents; and it is even possible that the muscular layers of the vaginal walls themselves may be controlled by it also to a certain extent. In the relief of neuralgic conditions of the pelvis, gentle Faradic currents are often most effective, and for this purpose I have found the positive pole (using an electrode of any kind of metal) decidedly preferable. For the muscular stimulation the negative pole if most effective. As a rule the electrodes required for galvanic applications may be used for this current, and a similar dispersion of current at the indifferent pole is advisable.

Beyond this neuro-muscular stimulation, with its therapeutic possibilities of direct and reflex effects, the Faradic current is powerless for either good or harm in gynæcology. It needs no careful watching to avoid untoward cauterizations or unexpected shocks; and the best guide to the strength of the current to be used is the sensations of the patient, the current having been brought up from zero to this point after placing the electrodes in position, in the same

gradual manner as advised for galvanic applications.

Interpolar Regions Unaffected by Faradic Currents.—An outline of the limitations attending the use of this current is incomplete without the fact being indicated that Faradic currents are only effective in any way in the immediate neighborhood of the electrodes. That extensive region between them, within which a current of large volume produces profound interstitial changes, is, with currents of such slight volume, without physical impress of any kind.

1706 Walnut Street.

APHORISMS ON DISEASES OF CHILDREN.

Compiled and translated by

CHARLES EVERETT WARREN, A. B., M. D., Harv.

From the French of E. Bouchut.

(*Continued from the preceding number.*)

239. It is the nature of some metastatic diseases to produce similar lesions in different tissues and parts of the body remote from each other.

240. The danger of ulcerative, gangrenous, and membranous angina is not always in the anatomical lesion, but in the general implication of the whole system, due to infection, by absorption, of the gangrenous and septic products.

241. The anatomical product of fibrinous angina is dangerous only when it obstructs the air-passages, constituting croup or diphtheria, mechanically causing asphyxia the same as any other foreign body.

242. A material, anatomical lesion never characterizes the nature of a disease; that is to say: There are false membranes and false membranes, as there is pus and pus.

243. False membranes may exist of any size in a child that is healthy and that will remain so; malignant and fibrinous inflammation alone secrete those endangering life.

244. Malignant angina, followed by croup, fatal on account of purulent, acute auto-inoculation, has no visible characteristics, although false membranes may mechanically obstruct respiration and engender anæsthesia more or less marked in character.

245. General inoculation of the system by malignant, ulcerative, gangrenous or fibrinous angina, produces desquamation of the uriniferous tubules, albuminuria, small hemorrhagic spots in the lung and sometimes small metastatic abscesses of the lung, the subcellular cutaneous tissue and nails.

246. Infection by malignant angina (diphtheria) is analogous to purulent infection (pyæmia).

247. General fever and asthenia, local ulceration, grangrene and membranous exudation in the throat, with or without odor, concurrent with dysphagia, engorgement of the cervical lymphatics and general infection of the system, characterize malignant angina.

248. When malignant angina is accompanied by cough and audible hissing respiration (laryngeal), with or without diminished sensibility, there is danger of the development of croup.

249. Ulcerative, gangrenous and fibrinous angina occurs in the sporadic or epidemic type; in the last case, always malignant.

DIPHTHERIA.

250. He who has seen diphtheria travel from town to town, from house to house, in the footsteps of the inhabitants, spreading from a limited locality and forming new epidemics (*i. e.*, foci of contagion), cannot for a moment question its contagious character.

251. Diphtheria is less severe in its results in adults than in children, but it may pass from the children to the parents and may devastate the whole family.

252. Diphtheria may kill the patient within twenty-four or forty-eight hours; its devastating course is the more rapid the younger the child.

253. "Would'st thou escape diphtheritic infection? then," says Carnevale: "Depart from its vicinity quickly; travel far from it and retnrn at the latest moment.

254. If the first manifestation of diphtheria can be entirely destroyed, nipped in the bud as it were, by thorough cauterization or by excision of the tonsils, infection of the system may be prevented and the disease quickly cured.

255. When true diphtheria is once established, death takes place by pyæmia or septicæmia, or by occlusion of the air passages by the membrane.

GANGRENE OF THE MOUTH.

256. Gangrene of the mouth, exclusively a disease of infancy, is always the result of impoverishment of the system by former diseases, such as measles, scarlatina or typhoid fever, recognized as the determinate cause of such, from aphthous or ulcerative inflammation of the buccal membrane.

257. Ulcerative stomatitis and aphthæ of the cheek are often the foci of gangrene of the mouth in infants thus predisposed.

258. Painful and tense swelling of the cheek at the line of the lower jaw, in a child having ulceration of the buccal mucous membrane, portends gangrene of the cheek.

259. Painful swelling of the cheek, with extremely fetid saliva and enlargement of the submaxillary glands, indicate the commencement of gangrene of the mouth.

260. When gangrene of the mouth extends and involves the cheeks, a small blister appears under the skin, which becomes first purple, then black, of greater or less extent; an eschar resulting, the whole thickness of the skin and the gums mortifying so as to expose the bone.

261. In gangrene of the mouth, the teeth deprived of their support, the gums, become loose and fall out, the maxillary bone being exposed.

262. Gangrene of the mouth, at first limited to one side of the face, rapidly extends and involves both sides of the face, eating away all of the integuments even to the eyelids.

263. Children afflicted with gangrene of the face suffer but little, the thirst is slight, the appetite is good and there is no fever noticeable.

264. In advanced stages of gangrene of the mouth, stupor intervenes, with great prostration, excessive pallor, marked weakening of the pulse and cold extremities, indicative of blood-poisoning.

265. In gangrene of the mouth, death results, as a rule, from lobular pneumonia or from the absorption of pus (pyæmia).

266 Gangrene of the mouth is often accompanied with gangrene of the vulva and anus.

267. Gangrene of the mouth is curable, but only when its ravages have extended but slightly; even then it leaves cicatrices, greatly altering the symmetry of the features.

268. Chlorate of potash internally, quinine, arseniate of soda, proper alimentation, and cauterization with acid or the hot iron, are methods in common use to arrest, limit and cure gangrene of the mouth.

269. A gaping mouth, with dry and purple lips, indicates ulcerative stomatitis.

270. Cauterization quickly cures internal ulceration of the mouth.

271. Aphthæ, becoming gangrenous, are always the point of departure of gangrene of the buccal walls.

272. Gangrene of the mouth usually occurs in weak infants, poorly-nourished and lymphatic, the victims of poor hygienic environment.

273. Gangrene of the mouth is sometimes epidemic.

274. Gangrene of the mouth often exists concurrent with gangrene of the anus and the genitals.

275. Gangrene of the mouth is marked by fetid breath, peculiar to this disease and known as gangrenous.

276. Excessive fetor of the mouth, with acute and circumscribed swelling of the face, indicates an approaching invasion of gangrene.

277. Gangrene of the mouth, extensively involving the skin of the face, is fatal.

278. Gangrene of the mouth, spreading over the face, leads to mortification of the gums, falling out of the teeth, and necrosis of the maxillary bone.

279. Gangrene of the mouth is curable only at its first appearance, and then only by deep cauterization repeated several times daily.

280. Hydrochloric acid, applied with a brush, is preferable to all other caustics in the treatment of buccal gangrene.

THRUSH.

281. A special form of inflammation of the mouth, modifying the secretion of mucus, rendering it acid, engenders thrush.

282. Thrush is characterized by an albuminoid concretion, filled with "oidium albicans," forming on the surface of the mucous membrane of the mouth.

283. Small, white granulations, discrete or confluent, resembling flakes of curdled milk, scattered throughout the mouth, characterize thrush.

284. Thrush is rarely a primary disease in infants.

285. Thrush commonly appears at the end of every severe acute disease, and during the course of chronic maladies.

286. Thrush ordinarily indicates a severe general disease or an impoverished condition of the system.

287. Thrush occurring during the course of chronic maladies, in those of mature years, usually portends imminence of death.

DIARRHŒA.

288. Diarrhœa, in children at the breast, is sometimes independent of inflammation or other material lesion of the intestine.

289. In children, diarrhœa is often a catarrh, due to cold, or mental impressions, poor hygiene, over feeding, or from indiscretions and mental impressions of the nurse.

290. Diarrhœa, in children, is often sympathetic with inflammation of the mouth during dentition.

291. Diarrhœa is very common in bottle-fed children. A rule without exception.

292. Too much milk or irregularity in feeding invariably produces diarrhœa.

293. Diarrhœa, unaccompanied by fever, with yellowish, homogeneous stools, is generally of slight importance.

294. Yellowish stools, turning green when exposed to the air and to the action of the urine, are not of serious import.

295. Stools of a yellowish-green color or variegated, with clots of casein, indicate serious irritation of the intestine.

296. Copious, serous stools are always of serious portent.

297. Bloody stools in children, with intestinal hemorrhage, are very grave symptoms.

298. Diarrhœa, accompanied by fever and of long duration, indicates entero-colitis.

299. Diarrhœa, simulating cholera, indicates the existence of a very severe entero-colitis.

300. Ordinary, acute, intestinal catarrh, spasmodic in its occurrence, can be and should be easily and quickly cured.

301. Chronic diarrhœa, in infants, leads to enlargement of the abdomen—bloating—due to tympanites, and also causes swelling of the mesenteric glands.

302. Simple intestinal catarrh, if allowed to run on, always engenders intestinal inflammation.

303. It is an unsound doctrine to allow the diarrhœa accompanying teething to go on unchecked or to encourage it.

304. Every case of diarrhœa, even the slightest, ought to be treated, at once, with remedies capable of checking it.

305. The cure of diarrhœa can often be effected by simple change of nourishment or by regulation of the hours of nursing, making them less frequent.

306. A variety of foods should be tried until that is found which is best adapted to the needs of the child.

307. Diarrhœa resulting from too early indulgence in solid food is quickly cured by a return to milk diet.

308. Simple intestinal catarrh may be cured by baths; astringents, internally; sub-nitrate of bismuth and opiates, the latter given carefully in all cases, whenever used, for whatever purpose.

ENTERO-COLITIS.

309. Inflammation of the digestive tract, in the infant, occurs most commonly in the large intestine, less frequently in the small intestine and very rarely in the stomach. The name of "entero-colitis" which I (Bouchut) have given it is therefore not a misnomer, but well merited.

310. Entero-colitis is the natural result of a poor regimen, poor breast milk, bottle feeding, premature use of solid foods, fats and other articles, and indigestion aggravated by indiscretions in eating and in action by the mother.

311. Fever; vomiting; green stools, clotted or serous; emaciation and flabbiness of the skin are indicative of entero-colitis.

312. Blanching of the face and dejection of the countenance prognosticate an impending attack of acute entero-colitis.

313. A leaden pallor and waxiness of the visage, with flabbiness of the skin and sinking in of the eyes and jaws, indicates acute entero-colitis of a choleriform type.

314. A child at the breast, having excoriations on the buttocks, the interior of the thighs and the malleoli, is suffering from entero-colitis, acute or chronic.

315. An enlarged abdomen with eventration, that is, general relaxation of the abdominal walls and viscera, indicates chronic entero-colitis.

316. A terrified countenance, aged and shriveled, in a young child, indicates entero-colitis.

317. Acute entero-colitis passes very easily and very quickly into a chronic enteritis.

318. Chronic entero-colitis, complicated by the concurrence of thrush, is of very grave portent.

319. Rapid and complete blanching of the color of the face, extreme and deep sinking of the orbits, following severe diarrhœa, foretell very great danger and probable death.

320. Chronic enteritis, of an ulcerative character, is nearly always fatal.

VARIOLA.

321. Variola attacks its victims according to their susceptibility; "it goes in through the blood and comes out through the skin."

322. The susceptibility to variola varies with age; it is great in the fœtus in utero, slight in the new born, very great during infancy, growing less in the adult and entirely absent in the aged.

323. Variola is often congenital.

324. Intra-uterine variola is, as a rule, inevitably fatal.

325. Variola is epidemic and contagious.

326. Variola may run a regular or irregular course, be discrete or confluent, benignant or malignant.

327. Variola in young children is almost always discrete, but often irregular, this fact making it of grave character.

328. A convulsion suddenly occurring, followed with fever and vomiting, in a child, who has not been vaccinated, suggests variola.

329. The susceptibility to variola is neutralized by inoculation with vaccine virus.

330. Variola, once established, follows the course marked out by nature with fatal accuracy; the eruption of pustules, upon the skin, cannot be prevented, except to a very limited extent.

331. Broncho-pneumonia is a very frequent and a very unfortunate complication of variola in children.

332. To properly treat simple, discrete and regular variola, energetic medication should be discarded, the physician contenting himself with prescribing rest and emollient beverages, the patient being placed in the midst of a pure, mild atmosphere.

333. The pustules should be aborted with proper applications of cerates, oils or collodions.

334. The complications of variola alone demand prompt and energetic action.

MEASLES.

335. Fever, accompanied with redness of the eyes, weeping, coughing and sneezing, is a premonitory symptom of measles.

336. Red spots, irregular, slightly raised and disseminated over the whole surface of the body, accompanied with fever and followed by furfuraceous desquamation, characterize measles.

337. Measles, beginning with convulsions, is always of grave portent.

338. Measles, uncomplicated by bronchial catarrh, always terminates favorably.

339. Measles, accompanied by bronchial catarrh, is often complicated by pneumonia.

340. The pneumonia of measles has a specific character, peculiar to itself, which modifies its development and renders it of very grave portent.

341. The pneumonia of measles is usually lobular and very often fatal.

342. The pneumonia of measles has a greater tendency than ordinary pneumonia to engender semi-translucent miliary granulations peculiar to phthisis.

343. Cases of measles of abnormal character are always of grave portent owing to the occurrence of sudden and unexpected complications.

INTERMITTENT FEVER.

344. Intermittent fever, in children,

differs greatly in character from that of adults.

345. The attacks are quotidian, occurring at indefinite hours, and there are only two well-marked periods, that of heat and that of perspiration.

346. In intermittent fever, in children, the chill is entirely absent, being placed by a sort of concentration of forces indicated by general and momentary blanching of all the tissues.

347. In children, as in the adult, an attack of intermittent fever, present or past, often brings about enlargement of the spleen, rendering this organ apparent to sight and touch as a tumor in the anterior abdominal wall.

348. In young children, and especially in the second infancy, a form of intermittent fever occurs, analogous in every point to pernicious fever, being considered as such.

349. After the third year of life and during the second infancy, intermittent fever is of the typical character, with well-marked onset and three stages, as in the adult.

350. During the second infancy, intermittent fever may be symptomatic of various visceral lesions, especially of pulmonary tuberculosis.

351. Simple intermittent fever is, as a rule, easily cured; it may however determine very grave cachexies with œdema of the limbs and cutaneous hemorrhage.

352. Cinchona easily cures intermittent fever in young children; during infancy, the bark is the better remedy; but during the second infancy, sulphate of quinine takes the first rank.

ERYSIPELAS.

353. Erysipelas, in the new-born, is very frequent during epidemics of puerperal fever, often resulting from this epidemic influence, almost always breaking out at some cutaneous wound, especially that resulting from the cutting of the umbilical cord.

355. Erysipelas in the new-born is almost invariably fatal.

356. Erysipelas in children becomes of less and less grave portent as it occurs at a period remote from the first month of life; during the second infancy the danger is no greater than that of erysipelas in the adult.

NÆVUS.

357. There are two kinds of nævi: pigmentary and vascular. These are congenital alterations of tissue produced by the accumulation of pigment, and the increase to a greater or lesser extent, in number and volume, of the capillaries of the skin and their transformation into a spongy, erectile mass.

358. Pigmentary nævi never disappear, and erectile nævi almost always persist.

359. If an erectile nævus increases in size too rapidly and threatens to burst, it is best to destroy it *in toto*, or to transform it into tissue not liable to vascular degeneration.

360. Nævi become transformed into fibro-cellular tissue under the influence of vaccination, or antimonial (?) inoculation, or acupuncture, followed by caustic injections. They also disappear, forever, when attacked with caustics, such as Vienna paste.

SCLEREMIA.

361. Scleremia (induration of the cellular tissue) caused by insufficient nourishment, inanition and cold, results from some obstacle which checks the circulation in the cutaneous capillaries.

362. Scleremia is a disease peculiar to the new-born, occurring very rarely during the second infancy or in the adult.

363. Scleremia exists with and without œdema of the subcutaneous cellular tissue.

364. Scleremia may be general or partial.

365. Clamminess and harshness of the skin, with a marked reduction of the temperature, characterize scleremia.

366. In the new-born, acute, single, feeble and frequent cries, repeated every minute or two, are indicative of scleremia.

367. Scleremia almost always terminates in pneumonia.

368. Scleremia of the new-born is generally fatal.

369. Partial scleremia is sometimes cured, but general scleremia never.

370. Scleremia is less and less of dangerous import as it occurs at a remote period from birth.

371. Scleremia is essentially a disease of the new-born, but it is sometimes met with in the second infancy

and in adults under the form of thickening of the skin.

MUMPS.

372. Pain, with swelling of the parotid glands, in an infant, otherwise well, constitutes mumps.

373. Mumps lasts from five to eight days and terminates by resolution.

374. An epidemic influence, of unknown character, is the cause of mumps.

375. Mumps occurs more frequently in boys than in girls.

376. Pain in the testicle, in boys, or in the breast, in girls, occurring during an attack of the mumps, marks the metastasis of the disease to the testicle or breast.

377. Dry and warm applications suffice to cure the mumps.

378. Pain, with swelling of the parotid glands, in a child, suffering from fever, indicates an attack of parotiditis — a form of mumps.

379. Parotiditis almost always terminates in suppuration.

380. The majority of children attacked with parotiditis die.

OTITIS.

381. Sudden pain in the ear, followed by running of the ear, indicates acute otitis.

382. Escape of pus from an excoriated, auditory passage, and dulness of hearing, indicate chronic otitis and otorrhœa.

383. Little bones, or fragments of bone, expelled with and in pus, through the external auditory canal, are indicative of internal otitis, perforation of the tympanum, necrosis of the bone and incurable deafness.

384. Acute diseases often leave, after their apparent departure, a humoral state favorable to the development of otitis and otorrhœa.

385. Foreign bodies, introduced into the ear, or insects, or the larvæ of insects, developed in the external auditory passage, always give rise to otitis of a dangerous character.

386. Internal otitis and deafness often follow tuberculization of the temporal bone.

387. Meningitis, following in the course of an internal otitis, is the result of the extension of the disease of the ear to the membranes of the brain.

388. Intermittent convulsions and transient paralysis, occurring during otitis, caused by a foreign body, or an insect in the ear, are sympathetic complications.

389. Facial hemiplegia, occurring in the course of otitis, is a symptomatic phenomenon, indicative of disease of the temporal region and disintegration of the facial nerve.

390. To extract foreign bodies from the ear use astringent injections, and treat the otitis with iodide of potash, arseniate of soda, oil, etc.

RACHITIS.

391. Rachitis and osteomalacia form one and the same disease, modified only by the age of the individual.

392. Rachitis is osteomalacia in an infant.

393. Persistence of the fontanelles and retarded eruption of the teeth indicate the development of rachitis.

394. Enlargement (knotting) of the articulations with curvature of the diaphyses of the long bones characterize the second stage of rachitis.

395. These nodes, when accompanied with an inability to stand, or to walk, together with pain and softening of the bone, are characteristic of general rachitis.

396. Rachitis is an obstructive disease which retards the onward movement of development and growth, and arrests it at that stage which it has reached.

397. To rachitis is due the great number of deformities of the skeleton, of the head, the limbs, the thorax and the pelvis.

398. An antagonism often exists between rachitis and tuberculosis.

399. Rachitis may be induced at will by poor regimen and hygiene.

400. The premature use of meat and fatty or farinaceous foods, by inducing chronic enteritis, has caused more cases of rachitis than the most exclusive and absolute milk diet.

401. Deprivation of air, exercise and light, add greatly to the effects of bad food and poor nourishment in the production of rachitis.

402. The use of milk, butter, bouillon and light broths, aided by plenty of fresh air and sunlight, often suffice to effect a cure of rachitis.

403. Cod-liver oil (30 grammes daily) is almost a specific in rachitis.

RHEUMATISM.

404. Rheumatism is an inflammatory diathesis localized in the fibrous tissue.

405. There is an articular rheumatism, cardiac rheumatism, cerebral rheumatism, pleuritic rheumatism (pleuro-pulmonaire).

406. In children, rheumatism usually occurs in several joints and if simple, without complications, it is easily cured.

407. Rheumatism, confined to one joint (mono-articulaire), is very dangerous because of its long duration, frequently terminating with suppuration.

408. Rheumatism, of infancy, is sometimes associated with a general disease, variola, scarlatina or typhus, making it of especially grave portent, because of the probability of suppuration of the articulations.

409. Rheumatism of the brain, of the pleura and of the heart, never occur except as complications of articular rheumatism.

410. Slight pain, fever, with painful swelling and sometimes redness of the joints, passing from the one to the other, characterize articular rheumatism.

411. Chronic rheumatism is very rare in children.

412. Rheumatism yields very quickly when of an acute and general character to sulphate of quinine and, better still, veratrine.

GROWTH.

413. Growth is one of the most curious manifestations of motor force, which rules, directs and co-ordinates the creation and development of organized beings.

414. Growth takes place in accordance with absolute and regular laws, varying in each climate, in each race and in each sex, perverted only by disturbances incited in each organism by disease.

415. Diseases of youth always accelerate the movements of growth.

416. The growth resulting from the action of the diseases of youth is not so rapid as one would believe, at first sight; it is always greater in appearance than it is in reality.

417. The influence of disease upon growth ought to be directly proportionate to the febrile disturbance which accompanies it.

418. Exaggerated growth acts in its turn as an ulterior cause of disease and may, as a result, cause pulmonary, cardiac or paralytic affections.

PURPURA.

419. Purpura is a hemorrhage of the skin, the mucous membrane and viscera, due to loss of plasticity of fibrine.

420. Miliary hemorrhages of the skin and subcutaneous ecchymoses, with or without fever, charcterize purpura simplex.

421. Miliary hemorrhages from the skin, subcutaneous ecchymoses and escape of blood from the mucous membranes of the mouth, the nose, the lungs, the stomach, the bladder, etc., with or without fever, are indicative of hemorrhagic purpura.

422. Purpura may be idiopathic, but more often it is due to a disease of a typhoid, virulent or toxic character, or one that has become chronic, in its last stages.

423. Purpura, occurring in the course of a state of marasmus consequent upon a chronic disease, prognosticates imminence of death.

424. Simple purpura is easily treated; but it is not so with hemorrhagic purpura, which, by the loss of blood alone, may cause death.

425. The best remedy against purpura is perchloride of iron.

DIPHTHERIA.

426. A specific, ulcerative inflammation of the skin and mucous membrane, giving rise to infection of the system, characterizes diphtheria.

427. In diphtheria, the ulceration and gangrene existing beneath and around the false membranes is of more importance than the membranes themselves, for to this is due the erosion of the capillaries which brings about the absorption of putrid matter and the engorgement of the lymphatic glands.

428. The false membranes, themselves, are of slight importance, other than that when formed in the respiratory passages they form a mechanical obstacle to breathing.

429. There may be false membranes, without diphtheria, in a great many wounds, and they may be produced at will in healthy subjects; but there is

no well authenticated case (assertions to the contrary, notwithstanding) where diphtheria has existed without false membranes.

430. False membranes, without diphtheria, constitute a benign, non-infectious diphtheritis.

431. True diphtheria is infectious and malignant, and rapidly extends, accompanied with erosion, ulceration and gangrene of the tissues, with general infection of the organism.

432. Benign angina, uncomplicated by diphtheria, resembles benign diphtheritic angina. Croup is in fact simply an extension of this combination of lesions, the complications of infection being absent.

433. In true diphtheria there is a suppurative, ulcerative inflammation of the tonsils, the velum palati, the nasal fossæ and sometimes the respiratory passages and vocal organs, with swelling of the lymphatic glands of the neck and with albuminuria.

434. While the specific ulceration of diphtheria ordinarily shows itself upon the nasal, buccal and bronchial mucous membrane, it also appears upon the skin, wherever denuded of the epidermis, by impetigo, blisters, burns or any kind of wounds.

435. Buccal and tonsilar diphtheria, accompanied with cough, hoarseness and wheezing, is developing into croup, and if at the same time there is a progressive loss of sensibility, asphyxia is threatened in the train of sequences.

436. Asthenia and sudden decoloration of the gums, the lips and the face, prove beyond a doubt that general infection of the organism has taken place and death is imminent.

437. Diphtheria, sometimes sporadic, more often epidemic, plays the *rôle* and possesses the characteristics of all infectious and contagious diseases.

438. Diphtheritic tonsilitis is only an anatomical phase of malignant angina or gangrene of the throat.

439. Diphtheria, at first a local affection, which can be easily destroyed, *in situ*, by cauterization or excision of the tissues infected, becomes, more or less rapidly, a general disease, by absorption of putrid products engendered by it.

440. If cauterization or excision of the parts affected with diphtheria is accomplished thoroughly, and immediately, at the moment of invasion, the evil consequences of the disease may perhaps be averted.

441. Diphtheria is a general, infectious disease, only as it becomes so by the entrance of putrid and gangrenous elements into the blood and other fluids of the body.

TYPHOID FEVER.

442. Typhoid fever is a general, epidemic disease, sometimes contagious, which enters into action upon the whole body and modifies the blood, the intestines, the spleen, the lungs and the brain.

443. In infancy, typhoid fever may exist with lesions of the intestine, such as occur in simple enteritis and in several other diseases of a different nature.

444. The lesions of typhoid fever, in infancy, are: hypertrophy of the solitary and aggregated glands of the intestine, ulceration occurring only in serious cases, swelling of the glands of the mesentery, and congestion of the spleen, the lungs, and brain.

445. Of all congestions of typhoid fever, that of the lung is of most grave portent, for it induces lobular hepatization, broncho-pneumonia and fatal asphyxia.

446. Typhoid fever in children is never twice alike. There are as many different combinations, typical peculiarities, and special differences as there are patients.

447. Typhoid fever presents itself in so many protean forms that its recognition by symptomatic signs is often difficult.

448. Continued fever, with lack of appetite, diarrhœa or constipation, pain in the right iliac region, with loss of vital energy, pallor and immobility of expression, characterize typhoid fever of the mucous type.

449. Continued fever, with redness of the face, vascular turgidity of the skin, constipation or diarrhœa, pain in the right iliac region, epistaxis and prostration, characterize typhoid fever of an inflammatory type.

450. Fever with uneasiness, delirium, dejection, stupor, bloating of the abdomen, pain in the right iliac region, coma, diarrhœa, voluntary or involun-

tary, rose-colored spots on the abdomen and chest, dryness of the tongue and blackness of the lips, characterize asthenic typhoid. On the other hand, it is ataxic, when, to these phenomena, is added muscular tremor, floccitation, coma and furious delirium, which nothing can moderate.

451. Typhoid fever accompanied with periodical, quotidian, febrile exacerbations, or other regular intermittent symptoms, constitutes remittent fever. It calls for quinine.

452. Frequent cough, accompanied with dyspnœa, supervening during the course of typhoid fever, indicates lobular pneumonia.

453. If thrush intervenes during the course of typhoid fever, a fatal result may be expected.

454. The vomiting of green matter, with chilliness and clammy skin, weak pulse, cyanosis and violent pain in the abdomen, indicate perforation of the intestine and portend death.

455. Hiccough, occurring in the course of typhoid fever, is usually a symptom of fatal portent.

456. Coma, occurring in typhoid fever, in infants, is almost inevitably fatal.

457. The enormous ulcers produced in the course of an asthenic typhoid fever seldom fail to kill the child.

458. Diarrhœa persisting in children having typhoid fever, but otherwise in good condition, indicates grave, enteric complications.

459. Inanition, prolonged for a long period, in typhoid fever in children, always leads to grave, nervous lesions and sometimes induces uncontrollable nervous vomiting.

460. Good nourishment is an essential point in the treatment of typhoid fever in children, and it should be commenced early in the disease.

461. At the commencement of typhoid fever, before it has taken definite form, an emetic or a purgative may completely divert the disease, or at any rate retard its further progress and favor the cure.

462. An emetic of sulphate of soda, aided by baths, acid and vinous drinks, by sulphate of quinine and suitable diet, will suffice in many cases to cure typhoid fever.

SCROFULA.

463. Scrofula is a diathesis giving rise to sub-acute or chronic swellings of all the organs which have a tendency to develop into tubercle.

464. In scrofula there are three stages which correspond to as many periods, namely: primary, secondary, tertiary.

465. Primary scrofula is characterized by an alteration of the lymph, inducing an alteration of the structure of the various organs, where the scrofulous diathesis first "wakes up."

466. Secondary scrofula is characterized by the development of scrofulous ulcers on mucous surfaces, in the glands, in serous tissues, in the skin and cellular tissue, in the different viscera, in the bones, etc., the result of latent or chronic inflammation of these parts.

467. The inflammation, typical of the second stage of scrofula, has a special course, slow, subacute and giving rise to serous suppuration, prolonged or resulting in cold, stationary ulcers of unlimited duration.

468. Tertiary scrofula is characterized by the formation of tubercles in the parts previously affected by secondary scrofula.

469. Tubercle in every form ought to be considered a result of scrofula.

470. Tubercles are always the product of a metamorphosis of prior scrofulous exudations, which have retrograded, that is to say, have died and fallen into a state of molecular degeneration.

471. These tubercles are often the sequelæ of acute maladies or eruptive fevers of earlier years.

472. Inasmuch as fibro-plastic granulations, the products of inflammation, transform themselves into tubercles, it is evident that tuberculization is the consequence of an inflammatory state.

473. Scrofula is almost always born with its victims, various external conditions causing it to develop at some subsequent period.

474. Scrofula transmits itself from the parents to the descendants, sometimes in a similar form, sometimes with different characters, metamorphic forms of hereditary scrofula.

475. When scrofula develops for the first time, in a generation, it is always the consequence of deprivation, indigence, bad regimen, unhealthy habita-

tions, dampness, absence of air and light or following eruptive diseases.

476. The tuberculous diathesis and the scrofulous diathesis, formerly considered as different, are one and the same.

Charles Everett Warren M.D.

TRANSLATIONS.

TYPHOID FEVER IN CHILDREN.—If the diarrhœa is very frequent give betanaphthol and salicylate of bismuth, each, 37½ grains, to be divided in ten powders and one administered every hour, dissolved in a little milk. So given, the medicine is well borne and is not repulsive. If the diarrhœa is less, the naphthol is given alone. If there be a tendency to constipation, the following is given:

℞ Naphthol.....gr. xxxviiss.
Salicylate of magnesia.... gr. xxxviiss. to gr. lxxv.

Divided into ten powders and administered as above.—*Revue de Ther.*

SACCHARINE was discussed by Constantine Paul at the Academy of Medicine, July 10th. The conclusions arrived at were that saccharine should not be considered as an aliment, but solely as a medicament. In this sense, saccharine possesses some special antiseptic properties which render it valuable in the antisepsis of diseases of the mouth, stomach, and perhaps of the urinary tracts.—*Bul. de L'Acad. de Med.*

INCONTINENCE OF URINE. (Hamon).—℞. Tincture of rhus aromatic 20 drops every night in a glass of water.

—*Revue de Thér.*

HYPODERMIC INJECTIONS OF SALT WATER.—The statements of Cantani concerning the treatment of Asiatic cholera by subcutaneous injection of salt water have suggested that the same treatment might be used in other grave conditions that cause failure of the heart. A solution of 6 in 100, of which 5 to 20 grammes may be used, is employed. No inflammation or abscess has been known to follow this, and after 20 to 30 grammes have been injected a marked improvement in the pulse is noticed, which continues for some hours. This treatment is indicated in the following cases: 1. Severe collapse. 2. Weakness of the heart. 3. Gastritis. 4. Acute enteritis. 5. Pulmonary, stomachic or intestinal hemorrhages. 6. Cachectic states.

—*Bul. Gen. de Thér.*

IODOFORM INTOXICATION.—M. Duret points out that there are three distinct forms of intoxication by this remedy: 1. The eruptive; 2, the cerebral or delirious; 3, the syncopal or hyperthermic. The eruptive form is the most frequent and has been studied in the thesis of Brun and in various German papers. It is characterized by a rubeolous eruption, showing upon different parts of the body and distant from the point of application. The toxic principles of iodoform are absorbed and it is probably their elimination by the glands of the skin that causes the eruption.

The cerebral form is characterized by epileptiform attacks or by insomnia accompanied by delirium. Many cases of this kind were seen in the clinic of M. Verneuil.

The syncopal form is the most serious; the absorption of iodoform is followed by subnormal temperature and chilliness. The temperature falls to 36° centigrade, and sometimes to 34.6°. M. Duret remarks that these symptoms usually cease when the iodoform is discontinued and recommends that it be employed with caution, in view of the accidents which may arise. Besides, in certain cases, iodoform has all the disadvantages of other inert powders, such as cinchona, etc. It provokes lymphangitis and phlegmon. He twice observed some inflammatory action in wounds of the fingers and hand, which ceased as soon as the iodoform was suspended.

—*Journal des Sciences Med. de Lille.*

HYDRATE OF AMYL IN CARCINOMA CONNECTED WITH UTERINE AFFECTIONS.

(Fischer)

℞ Hydrate of amyl..... 7 grms.
Distilled water.....60 grms.
Ext. of licorice.....16 grms.

M.—Take half upon retiring, the rest in the night. In case of gastric intolerance, prescribe the following draught:

℞ Hydrate of amyl..... 4 grms.
Chlorhydr. of morphine... 0 grms. .025
Distilled water .....50 grms.
Mucilage of gum arabic....20 grms.

Administer warm at bed time.—*Gaz. de Gyn.*

PHILADELPHIA
MEDICAL TIMES.

PHILADELPHIA, AUGUST 15, 1888.

EDITORIAL.

INSANITY AMONG THE TEUTONIC RACES.

THE *American Journal of Insanity* for April contains a very interesting article upon the above topic, by the Assistant Physicians of the Illinois Eastern Hospital for the Insane. Special attention is called to the frequency of mental alienation among our citizens of foreign birth. The depressive types of insanity are said to occur most frequently among those of Teutonic extraction, and least among the Celts; while mania is most prevalent among the latter.

There are some grounds other than *a priori* reasoning for believing that this may be the case. It would add to the interest of the paper, however, could we know by what rules the classification of races was made. In the present commingling of peoples it is by no means easy to select a pure specimen of any given type. The Irish may be classed as Celtic; yet the admixture of Norman, Scotch, and Saxon is very large in numbers and still more important in other respects. The descendants of the Normans who settled in Ireland, became "more Irish than the Irish themselves." In other words, the physical and mental superiority of that race was so marked that, when improved by grafting upon the native Irish stock, it at once took the lead in the affairs of Ireland. The great Irish leaders in war, their statesmen, orators, and poets, sprang largely from the Norman-Irish stock.

The Scotch-Irish element in Ulster produces men of the A. T. Stewart type, who are never seen among the happy, careless Corkonians or the somber peasantry of Connaught, whose blood is more purely Celtic.

The influence of Cromwell's conquest is shown in the prevalence of names which, like the long, muscular bodies of their possessors, recall the famous Ironsides who were settled upon confiscated lands, from which the owners were driven, "to hell or Connaught."

In Germany there is a certain admixture of Slav blood, from Poles, Bohemians, Wends, Slovenians, etc.; the last two of which have been assimilated by the Germans, but still modify their features and mental characteristics notably.

A physician in this city states that he comes from a village in Germany, whose inhabitants have been Wends for 700 years. Although they speak only German, their dark hair and eyes, smooth, insinuating manner and musical voice, are quite unlike the typical German of the day.

In France the Normandy peasant still shows marked differences from the other French; the Gascon's traits dimly recall his Gothic ancestors; but in general the Germanic conquerors have been swallowed up in the mass of the Celtic population. France is, perhaps, to-day more Celtic than any other part of the world, excepting Wales.

As for Italy, what have we of the old Roman blood? Even in the time of Scipio Africanus, he characterized the Roman populace as the descendants of Africans and Asians of many races, whose parents he had brought in chains to the Eternal City, while the Roman veterans had been transplanted to military colonies in all parts of the empire. In later days, every fresh swarm attracted to Italy by her wealth brought to her population a new element, and decimated all which preceded it. If we may judge by the language, however,

the conquerors of Italy have not proved more permanent than the English in India, where the latter race becomes extinct in three generations. None of the other descendants of the Latin tongue approach as nearly to the language of Cicero as does the modern Italian.

Clearly, we must look beyond the mere fact of the birth-place before we classify a subject ethnologically.

But in the conditions under which men now live we may find a more substantial basis for argument. It has been frequently remarked that the majority of shocking crimes, those whose atrocity suggests insanity, are committed by Germans. We refer to such horrors as that of Probst.

The system of universal compulsory education in operation in Germany may be in a measure responsible for this. The capacity of the human brain for the reception and retention of information is not an invariable quantity, and the subjection of all children to the same system of education is about as scientific as the method of Procrustes. In some cases the point of saturation is soon reached, and the further continuance of study only causes perplexity. Some brains imbibe knowledge much more slowly than others, and if these subjects are compelled to keep up with their classes, it is apparent that some derangement of the delicate cerebral apparatus may result.

We may at some period in the far-distant future reach such a degree of enlightenment that the teaching of each of our children will be suited to his capacities and directed towards making him useful in his future sphere; so that he whom Nature designed for a carpenter shall waste no time on Greek roots, but shall rather consider the veritable roots from which come the materials for his future labors, and that he to whom a pint mug of capacity has been given may not be compelled to swallow a gallon of mental pabulum.

To this mechanical system of education add the demoralization due to spending the best years of one's life in the army, the severity of the struggle for existence in Germany, and, withal, the want of that flexibility which enables an American to turn his hand to any occupation which offers, and the reasons why German intellects become so frequently unbalanced, become more tangible.

W. F. W.

THE CONGRESS UPON TUBERCULOSIS.

IF the reports in the secular press are to be trusted, the Congress devoted its time almost exclusively to discussing the etiology of tuberculosis. This is somewhat surprising, as the discussion must have been extremely one-sided, if, as is reported, there was but one man out of 450 who did not accept the transmission of the disease from cattle as a verity. Such unanimity is unusual in medical circles, and can only have arisen from the overwhelmingly convincing nature of the proof submitted. We are pleased to see that the stand we took early in the season, as to the objections to milk as a diet, is being confirmed. It seems as if, in truth, when attention was once directed to the subject, a most fruitful field for observation was opened up. The question of heredity is also made somewhat more perplexing, by the difficulty of eliminating such sources of tubercular infection as suckling with infected milk.

The practical outcome of the labors of the Congress appears to be summed up in the direction to "Eat your meat well done, and use no milk except such as has been well boiled."

Nothing was developed concerning the treatment, but a wise suggestion was made by an American delegate, that sanitaria should be established for the special study of this disease and of the various methods of treating it. When we reflect how large a proportion of the human race fall victims to the tubercle bacillus, it is remarkable that such institutions have not been already established. W. F. W.

CHARITIES, REAL AND NOMINAL.

THE English journals are beginning to awaken to the abuse of so-called charities in the guise of hospitals. The Medical Press adverts to the class who "only know that to give money profusely in charity is the correctly respectable thing to do, and that the most gratifying way of doing it is to lavish a big sum upon the institution which—in the begging columns of the *Times*—presents the most imposing array of fashionable names and asks for the largest amount of money." These strictures may be not wholly inapplicable on this side of the Atlantic. It is a notorious fact that the extravagant management of some hospitals, which do little or no really charitable work, is sustained by generous gifts, which would be of the greatest value to more deserving institutions.

PHENACETINE.

THIS new antipyretic bids fair to have a longer lease of life than its immediate predecessors. It has proved efficient in pneumonia and other pulmonary febrile states. It is not soluble and is best administered in pill. Ten grains produce definite results, but it is best to administer two to three grains at each dose, repeated frequently. In the case of children it has proved safe and quite efficient. In hectic the effect is not as good as that of acetanilide. The temperature of malarial fevers and that of health are unaffected by phenacetine. Whether it will prove as efficient an analgesic as antipyrine may be doubted, though some reports appear to show that it is not devoid of value. We have used it in one case of pneumonia with good results. In one case of pneumonic phthisis the effect was favorable. The absence of any deleterious action should render phenacetine especially suitable in typhoid fever; in which it should receive a trial.

In sciatica and lumbago of long standing, and in gastric neuroses attendant upon structural lesions, it has given relief, when administered in a single large dose.

In another place we print a report concerning the Norristown Asylum, which, if not clearly disproved, throws such a light upon its management as to render any other answer to Dr. Corson's letter quite superfluous.

We receive such reports, however, with a very large grain of salt. The abuses of insane asylums have always been attractive subjects for the purveyor of sensations, and under his hands the story rarely lacks for interest.

We sincerely trust that when the facts are plainly laid before the public, it will be found that there is not much in the case. Still, the story of lax and incompetent management is exactly what is to be expected when the affairs of an institution are in the hands of a non-resident Board.

One point which is significant is that the Board appears to have the appointing and discharging of nurses. The necessity for the full control of these persons being in the hands of the physician is so great that, were we to be offered the alternative of giving up this authority or the privilege of prescribing drugs, we would not hesitate

a moment in choosing to retain the control of subordinates. No other element is so vital in the treatment of the insane.

Meanwhile, the gravity of the charges made against the hospital management, and the high standing of the journal in which they were published, alike demand a reply from the authorities of the institution.

MEDICO-CHIRURGICAL HOSPITAL.

Service of WILLIAM F. WAUGH, M.D., One of the Physicians to the Hospital.

A CASE OF THERMIC FEVER.

Reported by MANLEY F. GATES, M.D.

JAMES BENNETT, a laborer, aged 44 years, was brought to the hospital on August 7, at 5 P. M., suffering from a sunstroke.

When admitted, he was comatose, his face was flushed, the body relaxed and he was breathing stertorously. His pulse was 140 and the axillary temperature 108° F.

His clothing was at once removed, a bag of ice and water applied to his head, and the whole body rubbed with ice. Fifteen grains of antipyrine were given hypodermically.

The pupils were nearly normal, but soon began to dilate, so that at 6 P. M. they were fully dilated and irresponsive to light. By this time the temperature had fallen to 98.4°, and the ice was suspended.

At 7 P. M. the pulse was weak and the hands bluish; his whole condition denoting prostration. Ten minims of tincture of digitalis were then administered subcutaneously, as well as several syringefuls of whiskey. Frequent and profuse vomiting and purging ensued, with convulsive movements of the arms; which continued for over an hour.

Sometimes the movements of the hands resembled those made by pavers in ramming down cobble-stones. It was afterwards ascertained that at the time of the stroke he was performing similar movements.

At 8 P. M. the temperature had risen to 101.4° F. and the ice cap was reapplied, and a cold sheet wrapped about the body. The patient then began for the first to show signs of consciousness and was able to tell his name.

At 10 P. M. he was sponged off, dried and put to bed; with $\frac{1}{6}$ grain of morphine hypodermically and one ounce of wine of coca by the mouth. At midnight the temperature had fallen to 100.6° F., and the man was quite restored to consciousness.

The temperature gradually subsided, reaching the normal point about 9 A. M., and did not again vary beyond the normal limits.

The day following the stroke he was fed upon clam-juice, in small quantities, given hot, every three hours. At noon he drank a cup of hot coffee, and during the afternoon ate a soft-boiled egg.

August 9. He has had full diet today; is quite rational; pupils normal; says he feels able to go to work.

He is an Englishman and has been in America but a few weeks, not long enough to become acclimated. He had been working very hard, hoping to earn money enough to bring his family out from England. He is strictly temperate; to which the successful issue of his case is partly to be attributed. Discharged at 6 P. M.

The special features about this case are: the rapid reduction of the temperature from the fearful height of 108° to 98.4° in one hour, and the ease with which the symptoms of depression were dissipated by the use of digitalis and whiskey subcutaneously. It will be seen that the flushed face and stertorous breathing, with high temperature, presented the indications for which Dr. Packard recommends bleeding; and yet, without resorting to this operation, relief was quickly afforded and a very speedy cure secured.

It was feared that some difficulty would be experienced in nourishing this patient, as the vomiting was severe; but the clam-juice was not only retained, but appeared to relieve the sickness.

Finally, the suggestion is made that the human brain is not so formed as to withstand the temperature of 108° for a very long period, and that the most energetic means for abstracting heat should be put in operation at once, before irreparable damage is done.

EXSTROPHY OF THE BLADDER. REPORT OF A CASE.

BY W. H. WALLING.

RALPH M——, admitted to the Medico-Chirurgical Hospital, March 28, 1888, showed this deformity in a marked degree. The patient, a boy, born in the interior of the State, of very humble parents, was eight years of age at the time of his admission.

The case presented the following interesting features: The posterior wall of the partially formed bladder was developed sufficiently to form a strong wall or partition, which protruded like a hernia, through a somewhat circular opening in the abdominal wall, just above the pubic arch.

This mucous surface was about one and one-half inches in diameter, protruding from about one-half to three-quarters of an inch, and could be pushed back into the abdominal cavity.

The color was a pale rose, with brighter spots upon it.

The right ureter was normal, but the left appeared to be hypertrophied.

The anterior wall of the bladder was entirely wanting, and there was only a very rudimentary penis, with the partially formed urethra upon its dorsal surface. The pubic bones were not developed, being fibrinous, and there was no umbilicus, The testicles seemed to be normal, but the scrotum was not developed.

The boy was tall, thin, of light complexion, and quite bright for one in such a condition.

When admitted to the hospital there was much excoriation of the surrounding parts, caused by the constant dribbling of the urine. He was placed under strict hygienic treatment and various devices suggested to remedy the defect, which failed to meet the requirements. It was then deemed best to attempt the formation of a small, complete bladder, by turning a flap of skin down from the abdomen, and covering this with flaps brought from the inguinal regions. This difficult and tedious operation was performed by Prof. Goodman on June 7, 1888, at the hospital. It was complicated by the presence of an oblique inguinal hernia on the right side.

The patient being anæsthetized, an incision was carried from Poupart's ligament through the skin and superficial fascia one and one-quarter inches from the median line to about nine inches up the abdomen, on each side, and united at the top by a curved incision. The upper part was dissected down for four and one-half inches, being two and one-half inches in width. The edges of this flap were carefully stitched to the edges of the lower part, and the raw surface covered by flaps brought from the groin on either side; the skin of the abdomen brought over by stretching, so as to cover the raw surface left by the upper flap, leaving only the small spaces in the groins to heal by granulation. A drainage tube was inserted into the new formed bladder, a subsequent operation being necessary to form a urethra and modify the penis.

In dissecting and handling the flaps, great care was exercised, and a solution of fluo-silicate of sodium, 1 to 1000, was constantly used during the operation, which lasted ninety minutes.

The patient was placed upon a water bed—after being properly bandaged—in a sitting posture, with thighs well flexed. He rallied and the prospects were good for a recovery, but in about twenty-four hours suppression of the urine set in, and about thirty-six hours after this event he succumbed to uræmia.

The autopsy showed the intestines distended by fluid, but no peritonitis. The liver and spleen were normal. The right ureter was normal, the left markedly enlarged at the distal end, while both kidneys were considerably enlarged. The thoracic viscera were not examined, there being no indications of lesions or abnormality in that region.

LETTER FROM PARIS.

TUBERCULOSIS.

IT is admitted that the occasional cause of phthisis is the bacillus studied by Koch, and at once the practical physician thinks of trying to kill this micro-organism; but *a priori* that is an error. All those who have carefully studied tuberculosis admit that the bacillus is only the *occasional cause*,

and nothing more. Alone it cannot bring about phthisis; it must have an organism ready for its action. So that really what we should try for is not to kill the bacillus, but to modify the culture liquid—that is, to make the human body sterile to its action. This fact makes the laboratory work of great importance; for it is most likely that from such workshops of science we will get the best indication for our therapeutical efforts. It has been seen that the bacillus is difficult to cultivate *in vitro* in ordinary culture-liquids, and that it is exceedingly strong in its resistance to most of our physical and chemical methods, once it has reached adult life. The temperature of 60° to 70° centigrade, which will destroy most of the micro-organisms, has no effect on this one. And as to chemical action, Dr. Villemin, a son of the physician who first inoculated tuberculosis in animals, has just published a paper in which he studies the action of certain chemical substances on Koch's bacillus. He finds that there is a number of chemicals that do not prevent the culture, and in these solutions the colonies of bacilli develop very rapidly. Such are solutions of salicylic acid, benzoic acid, benzoate of soda, biborate of soda, chloral and phosphorus. A second lot are those solutions in which the culture is quite evident, but which do not permit the development so rapidly as the first-named. These are acetanilide, arsenite of soda, biniodide of mercury (of which so much had been hoped), caffeine, turpentine, eucalyptol (which had once been spoken of as a specific), iodide of potassium, terpine, terpinol, etc. Other substances seem to cause a delay in the culture of the bacillus: such are arsenious acid, boric acid, alcohol, benzine and creosote, iodoform and menthol. And, lastly, a few solutions prevent entirely the cultivation of Koch's bacillus; these are hydrofluosilicic acid, ammoniac, fluosilicate of iron, the same of potash, the polysulphate of potassium and the silicate of soda. All of these rather unusual preparations stopped the development of the bacillus. Professor Grancher has tried *in vitro* the vapors of hydrofluoric acid for four hours on a culture of the tubercular bacillus, but without any effect, as they continued their action as before. We have the opening of the great international congress for the study of tuberculosis this week in Paris, and we will speak of it in our next letter.

ELECTRICITY IN DILATATION OF THE STOMACH.

One of our local electricians, Dr. Baraduc, proposes to treat dilatation of the stomach by electricity: that is, faradisation *intra-stomachal*. The operation is performed as follows: a rheophore is placed in the stomach-tube so that the wire shall not be in direct contact with the mucous membrane, but remains close to the small bend of the stomach, and to the vasculo nervous plexus; while a piece of terra cotta ware is placed over a large portion of the stomach, which of course is much lower than normal. This method does not present any more difficulty than the usual one of washing out the stomach in such cases, and is intended to cause a constriction of the muscular fibres of the organ that have become relaxed, and to wake up, as it were, the atony of the solar plexus. It pulls up the stomach which has fallen from its diaphragmatic cavity, and replaces it in its natural place. The faradisation is kept up for ten minutes, and the current is allowed to increase slowly without causing any shock to the patient. The results seen are, first, an immediate disappearance of the pain and the vomiting; the return of liquid absorption, and an improvement in digestion of usual foods, with a rise of the stomach to its normal place.

UTERINE SENSATION.

The sensibility of the uterine mucous membrane was again up for discussion before the surgical society, owing to a case of M. Tillaux's, in which he tried the sensitiveness of the membrane and found that it was quite insensible to heat or cold, or to pricking with instruments, so that surgeons who hoped to make the diagnosis between a polypus and other tumors of the organ by sensibility will have to give up that sign. It has also another point of importance: that is, owing to the frequent cases of abortion produced by putting instruments into the uterus. It has been held

that the woman's evidence that she felt a painful sensation when something was introduced was of importance, but if it can be proved that the mucous membrane of the uterus is insensible, then this evidence is of no value, as abortion can be produced without the woman being made aware of it by painful sensations in the uterus. MM. Berger and Ribemont spoke of a series of studies they had made, which proved that the uterus was perfectly insensible to touch by instruments; but that the organ must not be shaken itself, nor must it be pressed upon. M. Terrier and other surgeons did not agree that the uterine mucous membrane was so insensible as M. Tillaux stated, as on passing sounds they found that there was always more or less painful sensation. Others found that the sensibility varied in different women. M. Bouilly seemed to have struck the real facts in stating that it depended on the state of health of the organ. It would seem in fact that when the uterus is in a good condition there is little if any sensation; but when there is endometritis its sensibility is increased. In any case the fact of sensibility being made use of to diagnose a fibroma from a polypus is not of much value as a sign.

NEW TREATMENT FOR GONORRHŒA.

Dr. Hamonic gives a new treatment for gonorrhœa that seems to be of great value. It is simply by using the vapor of iodine and passing it into the urethra. There is no pain, but resolution takes place in the inflamed tissues of the canal, while a dilatation is produced that keeps the urethra free. In any case it causes all discharges to disappear, no matter what the cause may have been. The apparatus used is composed of two sounds that are open at the ends and compressed one into the other. A small rubber balloon, which has a blowing apparatus on it, is charged with the iodine vapor (taken from metallic iodine which has been heated). This is blown into the canal by one sound and comes out by the other. An application is made daily and after about eight of them the patient will be found completely cured.

ICE TO CURE CROUP.

Dr. Bleynie, of Limoges, proposes to cure croup by the constant application of ice *to the throat*. He introduces a small piece of ice into the mouth every ten minutes during the whole twenty-four hours (little children take it without even waking). The ice should not be swallowed until it has nearly melted. This must be kept up until the false membranes have gone, which will be from two to eight days, and when they seem to be going, then give the ice every half hour, and the next day only every two hours; watch closely the throat for some days to follow, and, at the slightest sign of false membranes, return to the use of ice every twenty minutes, until it disappears. Give plenty of food and *wine* from the first. If ice cannot be had, cold water may be used, but this must be applied at least every three minutes, by irrigation of the throat. If this is carefully kept up it will be seen that the disease germs will not invade the rest of the organism, and the child will be cured rapidly. The great success of this simple method induces us to mention it, not but what ice has often enough been used in certain forms of sore throat.

BURNS.

Burns are common enough to speak of, as we often have to treat them; and a writer in one of our medical journals gives the following formula:

> Tannin,
> Alcohol at 95°....āā.. 4 grammes
> Ether sulph. rectified..30 grammes
> Paint the parts with this two or three times a day.

After the evaporation of the ether there remains a fine pellicle of tannin over the burn, that takes away the pain and inflammation, and the cure is much more rapid than with the various collodion preparations. The first painting of the part should always be preceded by a careful antiseptic washing, to take away any foreign substances that may have adhered to it, and all blisters must be punctured before applying the remedy. If there has been some time passed without any treatment, a slight coating of iodoform should be powdered over the part first.

ŒSOPHAGEAL CANCER.

What to do in the difficult cases of cancerous constriction of the œsophagus

has occupied the communications of two of our best surgeons lately; one of them, M. Nicaise, had, performed gastrotomy, in a patient as the man had a constriction and was in a state of complete inanition. After the operation (which permitted alimentation by the stomach) a considerable amelioration was noticed. The patient gained in a week more than eight pounds, and lived for five months afterwards, when he died from the cancerous cachexia; but his gastric fistula did not present the slightest signs of irritation, and the food was retained when introduced. This may have been owing to the fact that the opening was made near to the pyloric orifice of the stomach. Dr. Nicaise concludes that this operation is to be preferred to the use of œsophageal sounds as a palliative in such cases. The passage of the sound only irritates the cancerous growth, and it is often difficult, painful and dangerous. Gastrotomy of itself is not a dangerous operation, and it allows of sufficient alimentation and gives the patient as much comfort as possible, and in some cases it allows after a time of their swallowing something by the usual route.

Dr. Kermission, on the other hand, had two cases of cancer of the œsophagus, and he used the method called "*sonde à demeure*"—that is, the sound is left in place after being introduced. The same sound can be left a long time, and is only taken out to clean it from time to time. The instrument used by M. Kermission was composed of two parts: a conducting *bougie* of whalebone and a rubber sound. The conducting bougie was invented by M. Verneuil, and when it passes the constriction the rubber sound is slipped over it. When the sound is passed, the anterior end is slipped into the nasal fossa, an ordinary urethral sound is passed into the nose, the connection is made between the sounds and it is fixed here with a diaper pin, or else a bandage is passed around the head to hold it. This allows the respiration to be carried on with the other nostril and the larynx as usual, while the sound is used for alimentation. This system certainly has the advantage of being applicable to not only cancers, but other constrictions of the tube (cicatrices and burns, etc.), and, after long dilatation, cure may be effected in the last named cases; but it seems to us that in cases of real cancer the first named operation is the best, and gives the most relief to the patient.

PEPTONIZATION.

An interesting note from M. Marcano, to the Academy of Sciences, shows how the peptonic fermentation of meat is accomplished. It results from his experiments that the faculty of peptonizing the albuminoids resides in the living vegetable cell, just as it acts on sugar and forms alcohol. This was seen by adding to hashed meat not only vegetable juice, but also the plant itself, when the solution of the fibrine was accomplished in from five to six hours, while if it is heated to 70° centigrade, the magma becomes liquid and gives a highly concentrated solution of peptones. From which we see the importance of a diet consisting of living vegetable fibre as well as meat fibrine.

THOMAS LINN, M.D.

ADDRESS.

DELIVERED AT THE OPENING OF THE SECTION OF OBSTETRIC MEDICINE, AT THE ANNUAL MEETING, BRITISH MEDICAL ASSOCIATION, GLASGOW, AUGUST 7, 1888.

BY THOMAS MORE MADDEN, M.D., F.R.C.S.ED.,

President of the Section; Obstetric Physician, Mater Misericordiæ Hospital, Dublin; ex-President, Obstetric Section, Royal Academy of Medicine; Physician, St. Joseph's Hospital for Sick Children; formerly Examiner in Obstetrics and Gynæcology, Queen's University; and Vice-President, British Gynæcological Society, London.

GENTLEMEN—I gratefully appreciate the honor of my election to the Presidency of this important section of the British Medical Association; which I regard as a compliment to the Dublin School of Midwifery, with which I have been long connected, rather to an individual otherwise so unqualified for the distinction as myself. I shall therefore trust to your continued indulgence for condonance of whatever shortcomings may be observable in my attempt to discharge the duties now entrusted to me.

The present meeting of the Association should, I think, be especially val-

ued by the members of this Section; for it is to Scotland, and to the genius of her sons, that the twin sciences of obstetrics and gynæcology—which we are here met to cultivate—owe their earliest development in Great Britain; and to a large extent their recent progress is traceable to the same source.

Long before there was any systematic teaching of midwifery either in Dublin or in London, and fully twenty years before the foundation in the former city of the great maternity hospital—on the staff of which I served my apprenticeship to the obstetric art—a Professorship of Midwifery was, in 1725, established in the University of Edinburgh; and I have had in my possession the ancient manuscript notes of the obstetric course delivered there in 1756 by Professor Young, as well as of the lectures of Dr. Hamilton, by whom he was succeeded. From that time the obstetric teaching of the Scottish schools has come down in an unbroken continuity of excellence to our own day, and its character has been amply maintained by the reputation of their alumni. Thus it was to William Smellie, a native of Lanarkshire, that our professional forefathers owed a "System of Midwifery" as far in advance of any that had preceded it as the obstetric science of these last twenty years of the nineteenth century has progressed beyond that taught in 1752 by Smellie. To the same writer is more especially due the credit of the first real improvement on Chamberlen's original forceps, as well as directions for using that instrument, as he said, "on rational and mechanical principles," which even yet might be studied with some advantage by modern obstetricians.

It was in this country also that the mind of William Hunter received its early training in that obstetric art which he afterwards so successfully cultivated and practised in London, and of which he there became the most distinguished of all its older British teachers. Nor even in this brief retrospect can it be forgotten that, in the city wherein we are now assembled, modern intraperitoneal gynæcological surgery was first anticipated in 1701 by Dr. Houstoun, in the curative treatment of an ovarian tumor by abdominal section. Whilst, more than a century later, it was to another Caledonian surgeon—Mr. Lizzars, of Edinburgh, whose early ovariotomy cases were published in 1825—that the revival, although in a very different and improved form, of Houstoun's first laparotomy operation is mainly due. I shall not attempt to follow further the long history of the obligations of our art to the older Scottish schools, or pause to offer my humble tribute of respect to the memory of one of their ablest teachers—the late Sir James Simpson, whose name will be recalled as long as suffering humanity seeks relief in anæsthesia, and as long as obstetrics and gynæcology are cultivated. Nor need I here refer to the services to our branch of medicine of Dr. Matthews Duncan, who filled the position I now occupy at the last meeting at Edinburgh of this Association, or allude to the well recognized gynæcological work of Dr. Keith, and of many other no less distinguished living Scottish authorities.

Whilst willingly acknowledging how much we owe to Scotland, I cannot omit a briefer reference to the similar labors of the Dublin School, although the credit of not a few of the obstetric advances that originated there in bygone years has more recently been elsewhere appropriated. Thus, for instance, the employment of version as a substitute for craniotomy, as advocated by some modern German and English writers, was first suggested in 1752 by Sir Fielding Ould, the second Master of the Dublin Hospital, and was revived a century later in the same place by the late Dr. McClintock, whose genius, erudition, and obstetric skill entitle him to remembrance even in our most oblivious of professions. In like manner, the management of the third stage of labor by the method claimed as his own in the late Dr. Spiegelberg's recently translated "Text-Book of Midwifery," is practically almost identical with that followed in the Rotunda from time immemorial, as described several years ago in my edition of "The Dublin Practice of Midwifery." The resuscitation, moreover, of the use of the forceps, the prophylaxis of *post-partum* hemorrhage, and many other

improvements in the management of child-birth and the puerperal state—the introduction of which is claimed elsewhere—have, I may repeat, also emanated from the same practical school of midwifery.

The foregoing reference to the historic claims of the ancient Scotch and Irish centres of obstetric science might be readily expanded. Time, however, forbids my further trespassing either in this way or by any allusion to the better known services of the early fathers of English midwifery; and, as Raynald, Willoughby, Harvey, Cook, Chamberlen, Chapman, Giffard, Denman, and the host of other pioneers of obstetric knowledge, many of whose lives and labors are so well chronicled in Dr. Aveling's erudite "Biographical Sketches of British Obstetricians," I shall, therefore, devote the remaining portion of this address to the more practical consideration of the results of some of the recent developments of obstetric and gynæcological science.

The progressive improvement of midwifery practice has been strikingly evinced during the past few years. Thus the pathology and preventive treatment of intra-uterine death and abortion have been freed from much of their former obscurity and difficulty by the recent writings of Dr. Priestly. The prevalence of puerperal septicæmia, by epidemic outbursts of which, in my early days, I have repeatedly seen the crowded wards of a great maternity hospital decimated, has been largely diminished by the hygienic and antiseptic measures now adopted for its prevention. Whilst if septicæmia should still occur, we are now armed with more scientific means for the curative treatment of this disease, which some years ago was generally classed amongst the incurable *opprobria* of our art. In like manner by the adoption of improved methods for the prevention and treatment of *post mortem* hæmorrhage, that once frequent source of obstetric mortality has been almost completely removed. At the same time the throes and pains of labor have been rendered more endurable by the employment of comparatively safe anæsthetics, such as the mixture of two parts of ether and eau de cologne with one of chloroform, which, for nearly twenty years, I have found a generally efficient and agreeable anæsthetic in such cases. Moreover, by judicious instrumental assistance, we may now, in many instances, safely abridge the duration of that formerly often long-protracted period of parturient suffering, which, when a student, I have too often seen allowed to continue unrelieved for forty and fifty, and even for eighty, hours and upwards. Lastly, the former appalling frequency of child-destroying operations has been reduced in an exact proportion to the increasing employment of the forceps. Nor have the limits of the utility of this instrument, as a substitute for the cephalotribe, craniotomy forceps, cranioclast, *et hoc genus omne*, been even yet fully reached.

The Uses of the Forceps and its Improvement.—The main reason why any embryotomic instruments are still included in the ordinary obstetric outfit, appears to me the fact that most midwifery practitioners do not recognise sufficiently the compressive power of the long forceps, and, moreover, rely exclusively on some one form of forceps, whether the head be above or within the pelvic cavity, and without reference to the kind of mechanical power—tractile, lever or compressive—that may be specially required in each case. Desirable as it may be to carry as few implements as possible in the obstetric bag, it is, nevertheless, impossible to combine in any one instrument properties so distinct as those referred to. In operative midwifery there should, surely, be some definite proportion between the power employed and the resistance to be overcome. Hence it seems about as needless to resort to an instrument of such compressive and lever power as the double-curved long forceps to assist delivery in an ordinary case of delay in the second stage, as it would be to employ a steam-hammer to crack a walnut.

I have endeavored to carry out these views in the two instruments now exhibited, which have been considerably modified and, as I think, improved in the course of experience since I first demonstrated the use of their original models. The first is a short, straight traction forceps, the blades of which

are only six inches in length and are so curved as to fit the fœtal head very exactly, and so widely penetrated as to allow the scalp to protrude when applied, and thus protect the maternal passage during extraction. This instrument, as may be seen, is very portable, and, locking loosely, is easily applied; and being a really efficient tractor, as I have proved by experience of its use in upwards of three hundred cases, may, therefore, be employed in nine-tenths of the cases in which any instrumental assistance is required—namely, those in which delay arises from inertia in the second stage of labor.

The second instrument shown is intended only for cases of difficulty from disproportion or pelvic flattening. The blades are, therefore, of considerable length and strength, and are approximated by a powerful screw by which the amount of compressive force exercised may be exactly regulated. The affixed traction rods are closed or separated by a simple mechanical arrangement. This instrument, as will be seen, is not only a tractor and lever, but is a compressor of great power, with which the fœtal head may be gradually moulded out and compressed within the limits of viability, so as to admit of delivery through pelves from which a living child could hardly be otherwise extracted. I need hardly add that such an instrument requires very great caution in its use, and should be employed only in the exceptional cases for which it is designed, and as a substitute for embryotomic implements.

Recent Progress of Gynæcology.—The development of this branch of medicine, since our Association last met in Scotland, has been still more remarkable than that effected in the practice of midwifery during this period. Thus, for example, only a few years ago many of the most frequent forms of endo-uterine and peri-uterine disease were beyond the diagnostic and remedial reach of gynæcologists, then unprovided with those means of rapidly and thoroughly dilating the cervical canal, or with the many other methods of direct investigation, by the aid of which any well-educated practitioner may now recognize and treat endo-uterine, ovarian, tubal and other intra-peritoneal and pelvic complaints that baffled detection or treatment. Nor in those pre-antiseptic days could have been anticipated the wonderfully successful results since realized from laparotomy operations, and more especially ovariotomy, as well as from some still more recent developments of intra-peritoneal surgery in tubal and other diseases, including even peritonitis and cancer of the uterus, the latter a subject which has been recently elucidated in Dr. J. Williams' Harveian Lectures. In the last-named cases, however, it is a debatable question whether we should persevere further with the intra-peritoneal procedure for the removal of the uterus introduced by Freund, in view of the better results obtained from the vaginal method advocated by Dr. Martin, of Berlin; and also whether in the latter case the operation should be limited, as recommended by Dr. Williams and Dr. Braithwaite, to the removal of the cancerous portion, and not be extended to the extirpation of the entire uterus.

Only within the time referred to has the general correctness of Dr. Graily-Hewitt's views with regard to the importance and treatment of uterine displacements and flexions become commonly accepted. Neither were the symptoms and appropriate treatment of ovarian displacements understood until a more recent period, when attention was directed to them by Dr. Barnes' able paper on this subject in the *American Journal of Obstetrics*, and in a minor degree, perhaps, also by a memoir of mine on the same topic in the transactions of the Irish Academy of Medicine. Nor is it so long since the bearing of cervical lacerations on pelvic pathology, as first demonstrated by Dr. Emmet, of New York, first became recognized in this country. Finally, the diagnosis, importance, and curability of diseases of the uterine appendages, such as hydro- and pyosalpinx, together with several other of the causes of female suffering and death, were, in like manner, practically ignored by gynæcologists until within a very recent period.

Influences of Prejudice and Fashion in Gynæcological Progress.—In the

history of many of the successful developments of gynæcology just referred to, we may observe proofs not only of the progress of our art, but also of the two causes which have temporarily retarded its advancement. The first is the opposition generally offered in matters medical, as in most others, to all innovations, and the consequent reaction by which the pendulum of professional opinion is swung from one extreme to the other, exaggerated overestimation, thus generally succeeding to earlier adverse prejudices. The second is the potent influence of fashion on medical opinion and practice; for, strange as it may be why this should be the case, it is, nevertheless, true that—

"In physic, as in fashion, we find
The newest is ever the rage of mankind."

This is strikingly illustrated in gynæcological practice, in which it now seems almost as much the fashion to ascribe various obscure female complaints to ovarian and tubal disorders, as, a few years ago, it was to attribute similar ailments to uterine flexions and displacements; or as, ten years earlier, it was the mode to credit them to chronic inflammation, or what was then regarded as ulceration of the neck of the womb; or yet, a century previously, to set them down, in the phraseology of our professional ancestors, to "the spleen" or "the vapors."

Gynæcological Specialism and Woman's place therein.—In this connection I may venture to observe that I cannot agree with those who are opposed to the admission of women into the practice of our department of medico-chirurgical science, for which their sex should apparently render them so especially adapted. I can see no valid reason why any well-qualified practitioner, male or female, should not be welcomed amongst us. Nor if there are women who prefer the medical attendance of their own sex, does it seem fair that in this age of free trade they should not be afforded every opportunity of exercising their discretion in a matter so personal to themselves. For my own part, I greatly doubt that, in these countries at least, "the Lady Doctors" (as they are termed) will ever replace the ruder sex in the general estimation of their sick sisters. But, if not here, elsewhere there is unquestionably an ample field for female practitioners, and, more especially, in India and other Oriental countries, where millions of suffering women and children are fanatically excluded from the possibility of any other skilled professional assistance; and I therefore think that such practitioners are entitled to admission into our ranks in the British Medical Association.

Laparotomy in Relation to Gynæcology.—Foremost amongst the proofs of modern gynæcological progress, the most signal is that afforded by the results of abdominal surgery in the treatment of ovarian tumors, as demonstrated in countless cases at home and abroad, and in this country more especially in the practice of Sir Spencer Wells, Dr. Keith, Mr. Lawson Tait, Dr. Bantock, Dr. Savage, Mr. Thornton and other specialists in this department of operative surgery, which, not very many years since, was so loudly and unfairly decried. Whether this should encourage the present frequency of resort to laparotomy in the various other intra-peritoneal morbid conditions in which it is now advocated, or not, is, however, another question, and one which, I think, may be still advantageously reconsidered.

Treatment of Fallopian Tube Diseases.—With respect to the tubal diseases, to the operative treatment of which so much attention is now devoted, and which I have elsewhere fully discussed, I shall only here again observe that, whilst recognizing the fact that in some instances of pyo-salpinx and hydro-salpinx the removal of the diseased uterine appendages affords the only available means of treatment, and fully appreciating the surgical skill by which operations for this purpose have been brought to their present perfection, I have not, in my own experience, found laparotomy operations as generally necessary in such cases as they are apparently now deemed by others. On the contrary, I am confirmed, by increasing observation, in the belief that in some instances these tubal diseases, more especially in cases of hydro-salpinx, may terminate favorably without any surgical treatment, and, moreover, that in other cases such

collections, whether purulent or serous, may be evacuated by cautious aspiration through the vaginal roof. Very recently I had an opportunity of again proving the advantages of this method of treatment in the case of a lady, who, after many months of suffering, was sent to me from a distant country to have the affected uterine appendages removed; but whom I succeeded in relieving of her trouble, with the assistance of my friend, Dr. Duke, by aspirating the Fallopian tube, and thus removing about ten drachms of serous fluid from the distended duct. I would, therefore, still urge the expediency of a fair trial of other less serious methods of treatment before resorting to the extirpation of the uterine appendages in these cases generally.

Operative Treatment of Uterine Tumors.—It would be impossible, within the limits of this address, to enter at length into the consideration of a question so large and so controversial as the general necessity for surgical interposition in the treatment of uterine fibromata. This, I am glad to see, will be brought before you during this meeting by those eminently qualified to speak on the subject; and I trust that in the ensuing discussion new light may be thrown on the comparative merits of the various intra-peritoneal and vaginal surgical procedures advocated in such cases, as well as on the value of electrolytical treatment. Nor, in this connection, should the possibility of arresting the growth of these tumors in some instances by appropriate medical treatment, as well as the greater probability of thus effectively checking hemorrhage so occasioned, and more especially by the free administration of ergot and iodide of potassium, to which I have elsewhere called attention, be entirely lost sight of.

With regard to the former or surgical method, I may, however, venture to repeat that, in the majority of cases of interstitial and sub-peritoneal uterine tumors, no active treatment whatever appears to me essential; inasmuch as such growths seldom, if ever, destroy life, and in many cases become arrested in their development and quiescent in their symptoms at the menopause, or may even possibly disappear altogether in the course of time. The latter event is, however, far too exceptional to have much influence in determining the expediency of surgical treatment, and more especially that by öophorectomy, which is unquestionably called for in the case of fast-growing fibroids, giving rise to otherwise uncontrollable urgent hemorrhagic or pressure troubles, particularly when occurring in young patients.

With regard to hysterectomy, although exceptional cases may occur in which this procedure is necessitated, the average mortality that has followed its performance is such as to forbid its general employment, as an operation of election, in a disease the average mortality of which, when left to nature, is so comparatively insignificant; whilst as to myotomy, in view of its too common results, I can only repeat that it would appear to me a method by which a patient may be effectually removed from a tumor, rather than as an operation by which a tumor can be safely removed from a patient.

Treatment of Uterine Fibroids by Electricity.—Although I have so nearly exhausted the allotted limits of this address, I cannot omit a few words in reference to the latest and most promising of the methods available in the treatment of uterine fibromata—namely, that by electricity. Within the past year and a half, I have had occasion to try this method, in some ten instances, in my hospital and private practice; and so far as the arrest of hemorrhage is concerned, the result was most satisfactory, the bleeding being thus arrested in six of these cases. But with regard to the cure of the disease from this treatment, the possibility of which had been demonstrated in the experience of Dr. Apostoli and others, who had employed it on a much larger scale, I can only say that whilst I have not as yet seen the complete subsidence of the tumour affected in any of the cases so treated by myself, in three of them its apparent bulk became distinctly diminished even after six weeks' or two months' treatment of this kind. It should, perhaps, be added that in all these instances I used Dr. Apostoli's original plastic clay abdominal electrode, the current used being, of course,

monopolar and acting directly on the growth by the intra-uterine pole, and was obtained from a powerful Leclanche battery of an estimated maximum current strength of 250 milliamperes. In the first of my cases I employed the electrolytic negative current, but after a little experience I abandoned this, and in the subsequent trials used only the positive current, which, although non-energetic as a galvano-caustic, is far less liable to give rise to trouble, and from its decided hæmostatic action is more suitable to these cases of large hemorrhage producing tumors, in which alone this or any other active treatment seemed to me generally necessary.

If, however, the results obtained by Dr. Cutter, and, still more conspicuously, those recorded by Dr. Apostoli, from the employment of electricity—namely, permanent benefit in ninety-five per cent. of the cases of fibromata thus treated by him—should be confirmed, as I hope may possibly be the case, by the experience of those who are here about to discuss this disease, then we might well congratulate ourselves on having at last arrived within sight of the long sought-for safe and effectual curative treatment of uterine tumors.

The foregoing *résumé* of some of the recent developments of obstetric and gynæcological science, imperfect as it is, affords a sufficient vindication of our branch of medicine from the aspersions which have been poured upon its followers. These advances and their results are surely more than enough to show that those by whom so much has been accomplished are engaged in no narrow specialism; but, on the contrary, should rank high in that noble and ever progressive profession of medicine whose great objects are the prolongation of life and the relief of every form of human suffering.

In conclusion, gentlemen, it only remains for me again to thank you for the honor you have here conferred upon me, and for the patience with which you have listened to this address.

Female Apothecaries.—Russia has granted women permission to devote themselves to pharmacy, provided male and female students are not trained together.

REVIEWS AND BOOK NOTICES.

An Illustrated Encyclopædic Medical Dictionary. Being a dictionary of the technical terms used by writers on medicine and the collateral sciences, in the Latin, English, French and German languages. By Frank P. Foster, M.D., with 11 collaborators. Vol. I. A to C. pp. xii, 752. 4to. New York: D. Appleton & Co. 1888.

This is certainly the day of magnificent books. "A comprehensive medical dictionary giving adequate attention to English, French and German terms in the same vocabulary" is something which becomes at once a necessity for every physician who reads or writes.

In the limited examination we have been enabled to make of the volume before us, we have found the definitions technically correct, the whole work copious enough to satisfy the most exacting, and we have had reason to admire the industry of the author, who has found time to accomplish a task of such enormous proportions, while engaged in editing a great medical journal.

The typography and paper are fully up to the Appleton standard.

The Applied Anatomy of the Nervous System. Being a study of this portion of the human body from a standpoint of its general interest and practical utility in diagnosis; designed for use as a text-book and a work of reference. By Ambrose L. Ranney. Second edition, re-written, enlarged and profusely illustrated. pp. xxxv, 791. 8vo. New York: D. Appleton & Co. 1888.

The design of this book is sufficiently indicated by the title; and the manner in which the design is carried out, by the name of the author. The large number of illustrations is especially appropriate in a work upon the nervous system, which few could read with the same benefit without such aids.

The Hygiene of the Skin; or, The Art of Preventing Skin Diseases. By A. Ravogli, M.D. Cincinnati: Central Medical Publishing Co. 1888.

The author has written a book which, like some others, may be the subject of

adverse criticism as to its design, style, etc. Still the fact remains that he has here collected a goodly amount of information, much of which is of value, and yet is not to be found in the ordinary text-books on diseases of the skin. In the first chapters he gives the anatomy and physiology of the skin, following with the etiology of skin affections, speaking of morbid impressions, diatheses, viruses, age, sex, complexion, poisons, diet, air, water, cosmetics, clothing, etc.

We are sorry to see no mention of the influence of plethora upon the development of some skin affections, as this is rather a neglected subject, which would have been appropriate here.

Perhaps the most useful part of this work is the chapter upon cosmetics, in which will be found answers to many of the questions with which our lady patients sometimes worry us.

A LABORATORY MANUAL OF CHEMISTRY, MEDICAL AND PHARMACEUTICAL, containing experiments and practical lessons in inorganic synthetical work, formulas for over 300 preparations, with explanatory notes, examples in quantitative determinations and the valuation of drugs, and short, systematic courses in qualitative analysis and in the examination of urine. By OSCAR OLDBERG, Ph. D., and JOHN H. LONG, Sc. D. With original illustrations; pp. 435. Chicago: W. T. Keener.

The author has given us a very good manual of chemistry, including the more recent advances in that science. To those who desire a guide in the chemical laboratory, which is clear, succinct and yet not so condensed as to be unintelligible, the present work is to be recommended.

LETTERS TO THE EDITOR.

JABORANDI IN ALBUMINURIA GRAVIDORUM.

Editor MEDICAL TIMES:

In the case I shall briefly report below, and which is respectfully submitted for your review, I desire to call special attention to a few facts, and also to make these facts the basis for an inquiry which I feel sure your great experience and close observation will fit you to answer. The occasion for this request of you, or rather the reason for my reporting the facts at this time, is this: At a recent meeting of a noted medical society, I reported the case narrated below, and asked for reports of experience with the drug in similar cases. None of the members had had personal experience with it; but in the discussion one venerable member denounced the drug as dangerous and contra-indicated in cases similar to mine—all because of his own one painful experience in injecting an unknown strength solution of pilocarpine into the scalp of a bald-headed patient. While I have no desire to do aught but condemn the careless and altogether reckless use of remedies of unknown power, I at the same time recognize as short-sighted the condemnation of therapeutic agents whose values are underrated because, forsooth, their power has been discovered by a species of criminal negligence.

My reason for appealing to you is, that, through the influence of your widely spread journal, the profession may learn whether the results that so happily crowned my experiment were of accidental occurrence, or whether we have in jaborandi a therapeutic agent that promises great results in cases of pregnancy, where premature labor or puerperal eclampsia are too often the two horns of the dilemma.

Mrs. D., primipara, 21 years old, free from taint of disease, and the embodiment of health, when nearly five months along in pregnancy, began to bloat about the face, hands and feet. Inside of a month the anasarca became general—so much so that she could with difficulty get about. From a condition of perfect health she became subject to severe headaches at times, with some pain in the head nearly all the time. She was drowsy and sleepy much of the time. On examination the urine was found to contain from 40 to 75 per cent. of albumen by bulk. A sample of urine sent to a microscopist contained hyaline and other casts; and from the many consultations I made with medical compatriots I obtained little encouragement, either as

to the outcome of the pregnancy or the safety of the patient. In the next month I tried all the remedies that I had reason to think would have the effect of reducing the anasarca and the albumen. I finally settled down to the use of the compound jalap powder (changed to one to four) once to three times a week, with a teaspoonful three times a day of the fluid extract of jaborandi. Under this the anasarca was reduced and the albumen in the urine reduced from 20 to 50 per cent. by bulk. The headache almost entirely disappeared, and at the full term the patient was, after a labor of average duration, delivered of a perfectly healthy boy, who, as I write, approaches me with the not unfamiliar speech of "Papa, have you got a nickel?"

In three days after confinement all anasarca and albuminuria had disappeared, and the patient has since enjoyed the best of health. At no time during the treatment was there any evidence of ptyalism, bronchorrhœa or excessive perspiration. I used P. D. & Co.'s fluid extract.

Iowa. J. A. D.

[While jaborandi is a drug which should be given with care, there is nothing in the above case to contraindicate its employment; and it is to be doubted if any other medicament would have rendered the same service. Whatever is the morbific principle to whose presence in the blood the phenomena of uræmia are due, no other eliminant has in our hands proved of equal value.

—Ed. P. M. T.]

MISCELLANY.

A Demoralized Hospital.—Disclosures of a sensational character concerning the management of the State Hospital for the Insane, at Norristown, were made at the recent monthly meeting of the Trustees. The management of the institution is practically in the hands of the Executive Committee, and the report presented by that body to the Board showed not only the grossest mismanagement and neglect on the part of the employes, but downright cruelty, which in two cases resulted in bodily injury to the patients.

Mary Ritchie, who has passed her 80th year, had her arm fractured because she refused to take a bath. She was seized by two of the attendants, and in the struggle her arm was broken. Mary Green, one of the attendants, was discharged by the committee. Jacob Miller also had an arm broken by the attendants, and three of the men employed in the male department were discharged. These unfortunates had suffered most at the hands of the attendants, but it was stated that other patients had been treated in a shameful manner.

The committee also reported that the management of the farm and poultry-yard was in a chaotic state, and little or no attention had been paid to the stock. There was a general want of care and attention on the part of the employes that should not be tolerated.

In its report the committee says that the hogs had been allowed to run at large and have destroyed twenty-eight acres of potatoes; the cows suffer for want of attention; the cornfield was full of weeds, and the agricultural implements neglected. In the poultry-yard two patients and three persons on salary are employed at a cost of $47.50 per month. The poultry-yard management will be investigated, and the neglect on the part of the former will result in summary action.

The committee recommended a plan for improving the water supply at a cost of several hundred dollars, the present supply not being adequate.

Steward West presented a bill for $117 for engravings which he had purchased to hang in the dining-hall. Several members of the Board wanted to know where the steward got his authority to make the purchases, as it had not emanated from the Board. As the pictures looked well the Board decided to pay the bill, but notified the steward not to make any more purchases without first obtaining permission from the Board.

The physician's report shows there are 842 males and 826 female patients now in the institution.—*Phila. Record.*